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	151326	A. BUILDING 00 B. WING	07/26/2011

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UNION HOSPITAL CLINTON	801 S MAIN ST CLINTON, IN47842

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S0000	This visit was for a State licensure survey. Facility Number: 005055 Dates: 7-25-11 through 7-26-11 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Sandra Nolfi, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 08/09/11	S0000		
S0838	410 IAC 15-1.5-5 (b)(1) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsiblities. These bylaws and rules shall: (1) be approved by the governing board; Based on medical record review, document review, and interview, the facility failed to ensure their rules regarding discharge summaries were	S0838	Actions Taken to Resolve Issue:1. Education regarding required elements to be included in the Final Progress note, as outlined in the rules and regulations, was	09/07/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	carried out for 4 of 5 short stay patient charts reviewed (#N11, 14, 15, and 16). Findings included: 1. The medical record for patient #N11 indicated an admission for observation date of 06/23/11 and a discharge date of 06/25/11. The record lacked a discharge summary or a final progress note as specified in the Medical Staff Rules and Regulations. 2. The medical record for patient #N14 indicated an admission date of 07/11/11 and a discharge date of 07/12/11. The record lacked a discharge summary or a final progress note as specified in the Medical Staff Rules and Regulations. 3. The medical record for patient #N15 indicated an admission date of 04/06/11 and a discharge date of 04/08/11. The record lacked a discharge summary or a final progress note as specified in the Medical Staff Rules and Regulations. 4. The medical record for patient #N16 indicated an admission date of 04/06/11 and a discharge date of 04/07/11. The record lacked a discharge summary or a final progress note as specified in the Medical Staff Rules and Regulations.		and will be reviewed at the Medical Executive Committee (MEC) meetings on August 9, 2011 and September 7, 2011 and at Committee of the Whole on August 23, 2011. 2. A letter will be sent August 23, 2011 to all active, senior and provisional physicians on the medical staff re-educating them of the four required elements that must be documented in a short stay progress note, per rules and regulations. A poster identifying and reminding Physicians of the same information will be posted August 23, 2011, in key areas within the hospital. 3. Education was provided to the Medical Records staff on 07/27/2011 to ensure each short stay record is being analyzed for compliance. Any short stay discharge that does NOT include all four required elements will be routed back to the physician for completion. Responsible: Chief of Staff (Chair MEC); Medical Records Director and Coordinator. Further Actions/Monitoring Plan: 1. A performance improvement monitoring tool was developed by medical records for use in completing audits on 100% of short stay records each month to ensure that when a final progress note is used in lieu of a discharge summary, the progress note includes all four required elements: (outcome of hospitalization; Care disposition;	

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	5. The facility's Medical and Dental Staff Rules and Regulations, amended March 18, 2010, stated on page 4, ..."9. The final progress note for a stay less than forty-eight (48) hours must contain the following: (a) Outcome of the hospitalization (b) Case disposition (c) Provisions for follow-up care (d) Diagnosis." 6. At 4:00 PM on 07/26/11, staff members A1, A2, and A6 confirmed the records did not contain final progress notes containing all of the items specified in the Rules and Regulations, but indicated the records did contain all of those items in different forms in the chart.		Provisions for follow-up care; and Diagnosis). 2. The results will be reported monthly at the COW and MEC until at least 90% compliance is reached. At this time, this will become a quarterly and ongoing addition to the quarterly Medical Record Department report to Medical Staff. 3. The MEC will provide oversight for any necessary actions.	
S0932	410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based on medical record review, document review, and interview, the facility failed to ensure 3 of 3 patients admitted for bleeding problems (#N7, N8, and N9) and 1 of 1 infants admitted (#N15) had individualized care plans in	S0932	Actions Taken to Resolve Issue:1. The Care Plan policy has been revised and a Care Path policy has been reinstituted. 2. The care planning component of the electronic medical record system is being enhanced to allow the nurse to select from an expanded	09/12/2011

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	their records. Findings included: 1. Patient #N7 was admitted on 06/23/11 with diagnoses of gastrointestinal bleeding, anemia, NIDDM (non-insulin dependent diabetes mellitus), and hypertension. He/she received blood transfusions during the hospitalization. The nursing care plan failed to list any problems or interventions related to bleeding problems. 2. Patient #N8 was admitted on 06/15/11 with diagnoses of bleeding, anemia, malaise, and fatigue. He/she received blood transfusions during the hospitalization. The nursing care plan failed to list any problems or interventions related to bleeding problems. 3. Patient #N9 was admitted on 05/25/11 with diagnoses of gastrointestinal bleeding, rule out myocardial infarction, and urinary tract infection. He/she received blood transfusions during the hospitalization. The nursing care plan did contain a problem of abnormal bleeding times related to anticoagulant therapy, but did not contain any problems or interventions related to the other diagnoses.		list of problems, goals, and interventions. This enhancement will support the individualization of the care plan. 3. The care planning system currently utilized by the Special Care Unit staff is being replaced by the Soarian system which will facilitate care plan development for critically-ill patients. 4 Nursing staff are being re-educated about the care planning process and orientation content has been reviewed to insure nurses new to the hospital are individualizing care plans as appropriate to the patient.Responsible: Director of Nursing and Medical-Surgical, Special Care Unit Managers, and Information Systems.Date Fixed By: Nursing education is planned for August 22-September 6, 2011 with implementation of expanded care planning options by September 7, 2011 for the Medical-Surgical Unit and September 12 for the Special Care Unit.Further Actions/Monitoring Plan:1. Concurrent chart review by the Nursing Care Managers and retrospective chart review by the Nursing Leadership Team will be done monthly. 2. Findings from both concurrent and retrospective chart review will be reported to the Nursing Leadership Team on a monthly basis.3. A report for the electronic documentation system will be generated to the NCM if a care plan hasn't been initiated within 24 hours or reviewed daily.	

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	4. Patient #N15, a 7-month old infant, was admitted on 04/06/11 with a diagnosis of bronchiolitis. His/her nursing care plan listed adult problems and interventions with no pediatric modifications. The care plan listed a problem of "Alteration in comfort-pain" with a goal of "Communicates understanding of pain management program." Another problem listed was "Knowledge deficit relative to pain control" with a goal of "Communicates understanding of pain control efforts." The interventions for that problem were, "Instruct and assist with methods to help pain, i.e., splinting of surgical incision areas. Teach importance of communicating pain intensity to allow treatment." 5. The facility's policy AP 1100.025, titled "Care Plans", stated, "An individualized plan of care shall be in place for all inpatients, as well as observation patients. The RN is responsible for initiating the care plan within 24 hours of the patient admission. The care plan is computer-generated, utilizing current standards of care and any additional patient specific problems." 5. At 4:00 PM on 07/26/11, staff members A1, A2, and A6 confirmed the medical record findings.		Compliance issues will be monitored and tracked by the Nursing Care Managers with re-education and disciplinary action taken as appropriate.	

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S1024	410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation, document review and interview, the facility failed to ensure multi-dose vials were marked when opened to prevent outdated use in the emergency department. Findings included: 1. During the tour of the emergency department, beginning at 12:30 PM on 07/26/11 and accompanied by staff member A2, 2 of 2 vials of insulin were observed open, but not dated, in the medication refrigerator. 2. Manufacturer's directions on the vials were to discard the medication 28 days after opening.	S1024	Actions Taken to Resolve Issue:1. The policy, Stability of Injectable Vials, was reviewed at staff meetings for Emergency Department/Special Care Unit on July 27, 2011 and Medical-Surgical Unit August 18,2011. 2. A correspondence was sent August 16 to all staff about eduation on dating and labeling of multi dose vials. A second correspondence was sent on August 23, 2011 to nursing leaders to post for all staff reiterating dating and labeling multi-dose vials. The policy "Stability of Injectable Vials" was posted August 16, 2011 in key areas within nursing units. 3. Laminated signs were posted during this same time period in locations where multi-dose vials are housed. Responsible: Director of	08/15/2011

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	3. Review of the facility's policy, PP560, titled "Stability of Injectable Vials", stated, "A. General- All multi-dose vials will be used for 28 days after initial use unless otherwise stated by the manufacturer." 4. At 1:00 PM on 07/26/11, staff member A2 confirmed the vials of insulin should be dated when opened.		Nursing/Pharmacy ManagerFurther Actions/Monitoring Plan: 1. Starting August 2011 Pharmacy staff rounding daily to check for compliance. Additionally, Nursing Care Managers will monitor for compliance during daily employee and patient rounds2. Pharmacy will report any deficiencies to the respective department manager for follow up with staff. Education and or progressive discipline will be done depending upon result of performance monitoring. 3. Pharmacy will provide monthly results to Nursing Managers, Nursing Leadership, and Safety Committee until performance meets 90% compliance in all departments. The frequency of reporting will be re-evaluated and reported quarterly only if performance compliance is met.	
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on observation, document review and interview, the facility failed to ensure the defibrillators on the units, in the emergency department, and in the surgery department were maintained according to manufacturer's recommendations.	S1168	Actions Taken to Resolve Issue:1. The policy, Checking of the Crash Carts/Defibrillator Testing policy (AD 54.0) was revised August 2011 to require that the defibrillators are checked each shift 2. The defibrillator checklists were revised and put into use,	08/01/2011

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	Findings included: 1. During the tour of the emergency department, beginning at 12:30 PM on 07/26/11 and accompanied by staff member A2, the logs for the Philips HeartStart XL defibrillator on the crash cart evidenced documentation of daily checks of the device. 2. During the tour of the medical/surgical unit, beginning at 1:00 PM on 07/26/11 and accompanied by staff member A2, the logs for the Philips HeartStart XL defibrillator on the crash cart evidenced documentation of daily checks of the device. 3. During the tour of the special care unit, beginning at 1:30 PM on 07/26/11 and accompanied by staff member A2, the logs for the Philips HeartStart XL defibrillator on the crash cart evidenced documentation of daily checks of the device. 4. Review of the manufacturer's guidelines for the HeartStart XL defibrillator indicated under "Operational Checks", ..."Perform a Shift/Systems Check every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and		August 1, 2011, to accommodate shift checks rather than daily checks.3. Nursing staff and nursing leaders were educated regarding the change August 1, 2011.4. Indiana State Department of Health findings and corrective action taken was discussed and during staff meetings for Medical-Surgical Unit (August 18), Emergency Dept. (July 27), Ambulatory Care (August 18), and Special Care Unit Staff (July 27)meetings5. Nursing assignment forms were revised to support identification of the nursing staff member responsible for defibrillator checks each shift Responsible: Director of Nursing, Nursing Care Managers, House Supervisors, and Quality SpecialistDate Fixed By: August 1, 2011, with ongoing monitoringFurther Action/Monitoring Plan: 1. Quality Control Reports have been revised to include defibrillator check compliance per shift. 2. These reports will be submitted to and reviewed by the Performance Improvement Council on a quarterly basis. 3. The Crash Cart/Defibrillator Check Report has been revised to reflect the shift requirement and will be submitted and reviewed by Safety Committee on a monthly basis (starting August) for the next six months. Re-evaluation of reporting frequency will be completed at the six month	

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	accessories are present and ready for use." The guidelines listed exactly what to do to perform the Shift/Systems Check which included running the strip to verify all of the systems. 6. At 3:00 PM on 07/26/11, staff member A2 confirmed the defibrillator checks were not performed every shift as recommended by the manufacturer.		mark. In order to start reporting quarterly compliance for all areas must be at 95% or greater. 4. Nursing Care Managers will perform concurrent checks on daily nursing unit rounds.5. Night Administrative House Supervisors will perform concurrent checks on daily nursing unit rounds.	